

**DEPT OF LABOR AND INDUSTRIES  
CLAIMS SECTION  
PO BOX 44291  
OLYMPIA WA 98504-4291**

**Note: Please fold in thirds using  
marks along the left edge so the  
address will show in a window  
envelope**

To:  
Department of Labor & Industries

Claim No.

Date I changed physicians

**Please transfer my case**

Name of doctor

**From:**

Name of doctor

Provider ID #

**To:**

Address of new doctor

City

State ZIP

Reason for transfer

Today's date

Claimant's name

Address

City

State ZIP

F245-037-000 (PDF) case transfer card 11-00